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	185151	A. BUILDING _____ B. WING _____	C 09/15/2015

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F 000	INITIAL COMMENTS An abbreviated standard survey (KY23744) was initiated on 09/08/15 and concluded on 09/15/15. The complaint was substantiated with deficient practice identified at 'E' level.	F 000		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility policy it was determined the facility failed to ensure residents' comprehensive care plans were reviewed and revised when residents were assessed to have and were treated for a	F 280		9/26/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/09/2015

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potential scabies rash for one (1) of three (3) sampled residents (Resident #3) and seven (7) of seventeen (17) unsampled residents (Residents C, E, I, J, K, N, and Q). Interview and record review revealed Resident #3 was diagnosed and treated for scabies (an infestation of the skin by the human itch mite, Sarcoptes scabiei var. hominis, and is usually spread by direct, prolonged, skin-to-skin contact with a person who has scabies) on 08/25/15. Review of the resident's care plan revealed no evidence the resident's care plan had been reviewed or revised related to the resident's diagnosis of a contagious skin condition. Continued interview and record review revealed unsampled Residents E, N, and Q were assessed to have a potential scabies rash on 06/25/15; however, the residents' care plans had not been reviewed or revised to identify the change in the residents' condition. Unsampled Residents C, I, J, and K were assessed and treated by facility staff on 08/25/15 for a potential scabies rash, and the residents' care plans provided no evidence that the comprehensive care plans were reviewed or revised to reflect the residents' change in condition.

The findings include:

Review of the facility policy titled Care Plans, last revised October 2010, revealed the residents' care plans were designed to identify problem areas, and any risk factors that were associated with the problem areas identified by facility staff. The policy further stated care plans were to be revised as changes in the residents' condition occurred.

Review of Resident #3's medical record revealed the resident was evaluated by a dermatologist

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and was diagnosed with scabies on 08/25/15. Review of the resident's comprehensive care plan revealed no evidence staff had reviewed or revised the resident's plan of care when the resident was diagnosed or treated for scabies on 08/25/15.

Review of the facility's infection control log dated June 2015 revealed Residents E, N, and Q had been assessed to have a rash and were treated for a potential scabies rash on 06/25/15. Review of the residents' comprehensive care plans revealed no evidence that staff had reviewed or revised the residents' plans of care when they were assessed and treated for a potential contagious skin condition on 06/25/15.

Review of the facility's infection control logs dated July and August 2015 revealed Residents C, I, J, and K were treated for a potential scabies rash on 08/25/15. Review of the residents' comprehensive plans of care provided no evidence the residents' care plans were reviewed or revised when the residents were assessed to potentially have scabies on 08/25/15.

Interview with the Minimum Data Set (MDS) Coordinator on 09/14/15 at 12:30 PM confirmed she was responsible to review and revise care plans when changes in condition occurred for facility residents. She stated she reviewed and revised residents' care plans after reviewing physician orders daily. The MDS Coordinator stated she had just "missed it" and acknowledged facility residents' care plans should have been reviewed and revised when they were treated or diagnosed with a potentially contagious skin condition.

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F 280	Continued From page 3 Interview with the Administrator on 09/14/15 at 2:45 PM revealed care plans had been "spot checked" to ensure they were reviewed and revised as required related to any change in the residents' condition, and no concerns had been identified. However, she acknowledged when facility residents had been diagnosed or treated for a potentially contagious skin condition, the residents' care plans should have reflected that change in the residents' condition.	F 280		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441		9/26/15

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F 441	Continued From page 4 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This STANDARD is not met as evidenced by: Based on observation, interview, record review, a review of the Centers for Disease Control (CDC) and Prevention Guidelines, and a review of the facility policy it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection for one (1) of three (3) sampled residents (Resident #3) and eight (8) of seventeen (17) unsampled residents (Residents C, E, G, I, J, K, N, and Q). Review of the facility's Infection Control Log and interviews with the Infection Control Nurse, revealed on 06/25/15 facility staff treated Resident #3 and unsampled Residents E, I, N, and Q with Elimite Cream (a topical scabicidal agent for the treatment of infestation with Sarcoptes scabiei [scabies]) for a "suspected" scabies rash. Review of the CDC guidelines revealed scabies is caused by an infestation of the skin by the human itch mite (Sarcoptes scabiei var. hominis), and is usually spread by direct, prolonged, skin-to-skin contact	F 441		

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with a person who has scabies. Interviews with the Infection Control Nurse revealed even though the residents were suspected to have scabies, contact precautions were not initiated to prevent the potential development and transmission of the suspected disease to other residents and/or staff. Further review of the facility's Infection Control Log revealed on 08/25/15 (approximately two months later) Resident #3 had a skin scrape and was diagnosed with scabies. Interviews revealed on 08/25/15 facility staff treated Resident #3 and also treated unsampled Residents C, G, I, J and K for a scabies rash with Elimite Cream, and again failed to initiate any contact precautions to prevent the development and/or the transmission of the suspected or confirmed skin infestation of scabies, to other residents or staff.

The findings include:

Review of the facility policy titled Scabies, last revised August 2012, revealed the purpose of the policy was to treat residents infected with Sarcoptes scabiei (scabies) and prevent the spread of scabies to other residents and staff. The policy stated individuals who came in contact with the infected resident or potentially contaminated bedding or clothing should wear gowns, gloves, or other protective clothing as established by the facility's infections and exposure control program. The policy further directed staff to continue contact precautions 24 hours after the resident had been treated for scabies to prevent the spread of scabies in the facility.

Review of the CDC guidelines dated 11/02/10 revealed Scabies is an infestation of the skin by the human itch mite (Sarcoptes scabiei var.

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hominis). The microscopic scabies mite burrows into the upper layer of the skin where it lives and lays its eggs. The scabies mite usually is spread by direct, prolonged, skin-to-skin contact with a person who has scabies. CDC guidelines also stated Scabies can spread rapidly under crowded conditions where close body and skin contact is frequent. Institutions such as nursing homes, extended-care facilities, and prisons are often sites of scabies outbreaks.

Review of the Infection Control log dated June 2015 revealed on 06/25/15 facility staff treated Resident #3 and Residents E, I, N, and Q with Elimite Cream (a topical scabicidal agent for the treatment of infestation with Sarcoptes scabiei [scabies]) for a "suspected" scabies rash.

Interview with the Infection Control Nurse on 09/08/15 at 3:10 PM revealed she acknowledged Resident #3 and Residents E, I, N, and Q had been treated on 06/25/15 for a suspected scabies rash. She stated she had not initiated or directed staff to utilize contact precautions to prevent the potential transmission of the suspected scabies rash to staff and other residents. The Infection Control Nurse stated she was not aware that contact precautions should have been implemented for residents with potential scabies.

Review of the facility's Infection Control log dated July/August 2015 revealed on 08/25/15 (approximately two months after the initial treatment for scabies occurred in the facility) Resident #3 had a skin scrape (a procedure used to confirm the presence of scabies mites/eggs) at a local dermatologist and was diagnosed with scabies.

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Interview with Licensed Practical Nurse (LPN) #1 on 09/12/15 at 8:00 PM revealed she was the nurse for Resident #3 when the resident returned from the Dermatologist appointment on 08/25/15 with a diagnosis of scabies. The LPN stated she immediately notified the Infection Control Nurse of the resident's diagnosis, but stated she was not directed to implement any "special" precautions for the resident. She stated she had not directed any direct care staff to utilize contact precautions for the resident even though she was aware the resident had been diagnosed with scabies.

Interview with the Infection Control Nurse on 09/10/15 at 11:50 AM revealed she was notified of Resident #3's confirmed diagnosis of scabies on 08/25/15. The Infection Control Nurse acknowledged she had not instructed staff to utilize contact precautions, but stated Resident #3 was provided with treatment as ordered by the physician. She also stated skin assessments were conducted of other residents on 08/25/15 and Residents C, G, J, K, and I were also assessed to have a "scabies like" rash and were treated for scabies. However, she stated residents in the facility which had been assessed to have a rash, that was potentially scabies, had never been isolated, and no measures were taken to prevent the transmission to other residents and staff. She also stated even though residents had been treated "off and on" since June 2015 (approximately two months) to potentially have scabies, she had not referenced the facility policy or the CDC guidelines in an effort to ensure appropriate actions had been implemented for facility residents to prevent the spread of scabies.

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F 441	Continued From page 8 Interview with the Administrator on 09/14/15 at 2:45 PM revealed she was aware that residents had been treated for potential scabies rashes on 06/25/15 and 08/25/15. She also stated she was aware that Resident #3 had a confirmed scabies diagnosis on 08/25/15. The Administrator stated the facility policy or the CDC guidelines had not been utilized as a reference when facility residents "potentially" had scabies, on 06/25/15 and 08/25/15. However, she stated staff should have referenced the CDC guidelines and the facility policy related to scabies, to ensure appropriate measures had been taken for all facility residents to prevent the spread of scabies.	F 441		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of the facility policy it was determined the facility	F 514		9/26/15

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failed to maintain accurate and complete medical records for one (1) of three (3) sampled residents (Resident #3) and four (4) of seventeen (17) unsampled residents (Residents B, H, O, and P). Review of the facility's infection control log dated July 2015 and August 2015 revealed Resident #3 and unsampled residents B, H, M, O, and P were treated for a potential scabies rash in August 2015. Even though the residents had been treated for rashes, review of their weekly skin assessment sheets revealed no evidence staff had identified the rashes when facility staff assessed the residents' skin.

The findings include:

Review of the facility policy titled Skin Management and Prevention, last revised August 2013, revealed the facility's "weekly skin rounds sheet" would be utilized to determine if any new skin alterations had developed, and that all new skin conditions found during the weekly skin rounds would be documented on the weekly skin round sheets.

Review of the facility's infection control log dated July 2015 and August 2015 revealed Resident #3 and Residents B, H, O, and P were treated for a potential scabies rash on various dates in August 2015.

Review of Resident #3's medical record revealed the resident was diagnosed with scabies from a skin scrape conducted by a dermatologist on 08/25/15. However, review of the resident's skin assessment conducted by Licensed Practical Nurse (LPN) #1, dated 08/25/15, revealed no documentation of a rash.

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Interview with LPN #1 on 09/13/15 at 5:30 PM confirmed she had conducted Resident #3's weekly skin assessment on 08/25/15. The LPN stated she had not identified the resident's rash on his/her skin assessment form because "I guess I just overlooked it," and further stated that the resident "had a rash for a while."

Review of the facility's infection control log revealed Resident B was treated for a potential scabies rash on 08/27/15. However, review of the resident's skin assessment form dated August 2015 revealed the resident was not assessed to have a rash by facility staff.

Review of the facility's infection control log revealed Resident H was treated for a potential scabies rash on 08/21/15. However, review of the resident's skin assessment conducted by facility staff on 08/21/15 revealed the resident was not assessed to have a rash by facility staff.

Review of the facility's infection control log revealed Resident O was treated for a potential scabies rash on 08/27/15. However, review of the resident's skin assessment conducted by facility staff on 08/27/15 revealed the resident was not assessed to have a rash by facility staff.

Review of the facility's infection control log revealed Resident P was treated for a potential scabies rash on 08/21/15. However, review of the resident's skin assessment conducted by facility staff on 08/21/15 revealed the resident was not assessed to have a rash by facility staff.

Interview with the Director of Nursing (DON) on 09/14/15 at 1:30 PM revealed all licensed nursing staff had been trained to include any skin

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F 514	Continued From page 11 abnormalities on the weekly skin assessment forms for all facility residents. The DON stated the facility had a system in place to ensure skin assessments were conducted weekly as required. However, the facility had not identified that skin assessments were not completed accurately, when residents had been treated for a potential or a confirmed scabies rash in the facility.	F 514		